HC-One Limited

Burnham House

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

Burnham House is registered to provide accommodation for up to 72 older people who require personal or nursing care. The home has a dementia unit which is situated on the first floor. On the day of our visit there were 33 people living in the service.

The service did not have a registered manager in place at the time of this inspection. The registered manager left the service in January 2015. A new manager had recently been recruited. At the time of our inspection they had not submitted an application to register with the Care Quality Commission.

During our Inspection of the service in June 2014 we found that the provider had not met the requirements of the law in the following five areas:

- Care and welfare of people who use services
- Meeting nutritional needs
- Cleanliness and infection control
- Records
- Assessing and monitoring the quality of service provision

Summary of findings

During this inspection we found improvements had been made but further actions were required for the service to become fully compliant with the law.

There was not sufficient staff on the first floor to meet people's needs. Call bells were not responded to promptly. People told us they felt safe with the care they received. Staff demonstrated their understanding of how to identify abuse and what they should do if they suspected abuse had occurred. Staff administered medicines to people safely.

The service acted in accordance with the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Mental capacity assessments were undertaken for people who lacked capacity to make specific decisions. The service sought consent before carrying out care, treatment and support. Appropriate applications were submitted to the supervisory body to ensure people were being lawfully restricted. People received care and support from staff who received effective supervision, training and appraisal. People's nutritional needs were met.

There was a lack of social activities for people who lived in the home. Management were aware of this and showed us the measures being undertaken to address this. We have made a recommendation about staff training in regards to providing social activities for people living with dementia. People told us staff were caring and looked after them well. Staff confidently demonstrated knowledge of people's preferences, family history and care needs. People choices were respected. They told us staff listened and acted on their requests. People who received end of life care were monitored sensitively and effectively by staff. We have made a recommendation about the service seeking advice and guidance from a reputable source, about the management and monitoring of systems used in the home by people to summon help when required.

Reviews of care, risk assessments and care plans were undertaken regularly and were up to date. The service responded to the needs of people by making necessary changes when required.

Care records showed people received care that was focused on their individual needs. These captured people's preferences and expectations. People knew how to make a complaint if they had concerns.

The staff dependency tool used to assess whether staffing levels were adequate to meet the needs of people in the home was not regularly reviewed. There were no systems in place to monitor how quickly call bells were being responded to. The home had three managers in the previous 10 months. Some people were not aware of who the new manager was. One relative acknowledged there had been many changes in management but thought the care of their relative was not affected. Staff said the new manager was approachable and felt supported in their roles. The service gathered views of people but minutes of relatives and residents meetings did not record staff responses to the feedback received.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not safe.

Staffing levels did not meet the needs of the people on the first floor dementia unit. This meant people could not be confident their care needs would be met.

People were kept safe by staff who knew how to identify abuse.

The service administered medicines safely.

Is the service effective?

Good

The service was effective.

People received care and support from staff who received effective supervision, training and appraisal.

Procedures were in place to ensure staff with the right skills were able to meet people's individual needs.

People's rights were protected because the service acted in accordance with the Mental Capacity Act 2005 (MCA) and the Deprivation of (DoLS).

Is the service caring?

Requires improvement

There were some aspects of the service that were caring.

People's social needs were not consistently being met. There was no stimulation for people living with dementia.

People said staff were caring and looked after them well. Staff we spoke with demonstrated good knowledge of people they provided care, treatment and support to.

Is the service responsive?

Good

The service was responsive.

The service responded to the needs of people by making necessary changes when required.

Care plans and risk assessments were regularly carried out, up to date and reflected people's changing needs.

People knew how to complain if they had concerns.

Is the service well-led?

Requires improvement

The service was not well-led.

The staffing tool used to assess whether staffing levels were adequate to meet the needs of people in the home was not regularly reviewed.

There were no systems to monitor the response times of staff to call bells.

Summary of findings

The provider sought feedback about the service provided however, records of meetings held did not show how staff responded to the feedback received.

Burnham House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 6 and 7 April 2015. During our last inspection in June 2014 we found a number of breaches with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with the Health and Social Care Act 2014 (Regulated Activities) Regulations 2014.

The inspection team consisted of one inspector, a pharmacist inspector and a specialist advisor on the care of people with dementia.

Before the inspection we reviewed all the information we held about the service. We looked at notifications the provider was legally required to send us. Notifications are information about certain incidents, events and changes that affect a service or the people using it. The provider completed a Provider Information Return (PIR). The information in this form enables us to ensure we address potential areas of concern and any good practice.

Following our visit we received feedback from a health professional, care manager and an officer from the local authority who had been involved with the people living at the service. We also received feedback from a local commissioner of the service as part of the inspection process.

During our visits we observed how care was provided to people, how they reacted and interacted with staff and their environment. We spoke with eight people who used the service, three relatives, three registered nurses, six care workers, one activity co-ordinator, chef, manager and the project manager. We looked at 17 care records, 16 medicine administration records, four staff records, and records relating to management of the service. We used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Requires improvement

Is the service safe?

Our findings

During our inspection in June 2014 we found quarterly infection control audits had not been regularly completed; there was no designated infection control lead and staff did not always wear appropriate personal protection equipment (PPE). On this visit we found infection control audits had been regularly undertaken and appropriate measures had been taken to ensure people were kept safe from infection. The manager told us they had identified and were in the process of training a staff member to be the infection control lead. We observed staff wearing PPE during our visit. One staff member commented, "My infection control training is up to date. We wear gloves and aprons and ensure our hands are washed before and after administering medicines." One person commented, "Staff come into my room everyday. They wear aprons and gloves." This ensured people were kept safe from infection.

There were not sufficient staff to meet people's needs. We observed the staffing levels did not meet the needs for people who lived on the first floor dementia unit. The manager told us one registered nurse and two care workers were allocated to work on the first floor, with an additional care worker assigned to provide one to one support for one person. This was confirmed during our observations however, we saw staff struggled to meet the needs of the people they provided care to. For example, we noticed one person looked as if they needed a shave. We spoke with a member of staff who told us they normally shaved people in the afternoons as there was little time for this to be completed in the mornings.

One staff member told us they enjoyed the work at the home but even when there were four staff members on duty, staff still struggled to get the work done. This was because most of the people on the first floor were frail with complex needs and needed two people to assist with getting in and out of bed and transferring from bed to chair. The staff member felt the staffing levels were unsafe as they felt it was impossible to give people the person centred care they required. Another staff member told us, "I believe there is enough staff on the ground floor." However some staff believed there were enough staff on the first floor. One staff member commented, "There is enough staff, we can get bank staff to cover if staff become sick."

People who lived on the ground floor also voiced their concerns about staffing. For instance, one person said, "They need more staff, particularly after 3pm." A relative whose family member lived on the ground floor supported this and commented, "There is not enough staff. When I visit, I have problems finding staff especially at weekends and late in the evening." After our visit the home sent us the staffing tool used to assess the dependency levels for people who lived in the home. However, this was not completed and therefore we were unable to see how they ensured staffing levels in the home met people's needs.

This is a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's needs were not always met in a timely manner. We observed call bells were not always responded to promptly. The relatives of one person told us they felt the home was generally safe, however they said their family member had expressed concerns about staff taking a while to respond when they pressed their call bell. We observed this happen during our visit. We noted a person had pressed their bell and it took staff more than three minutes to respond to the person. During this time we observed a staff member walk pass the person's room whilst their bell was ringing. During our visits we noted another person kept continually pressing their bell. Management were aware of this and informed us of the on-going action they were taking to address the situation. They acknowledged that despite this individual's behaviour staff should always respond to call bells and they will continue to remind staff of this.

Following a recent visit to the home by the local authority, similar concerns around responsiveness to call bells were raised.

People told us they felt safe in the home. One person commented, "Yes, I can trust them. Staff always tell us who they are." One relative commented, "To my knowledge X is safe." Another person stated, "I am on my own at night." We spoke with the person's relative who told us the person had worked nights all their working life and had trouble sleeping as they disliked night time when they lived at home. The relative did not mention any other concerns about the home not meeting their relative's needs at night time.

People were kept safe as staff had undertaken relevant training, knew how to identify abuse and report any concerns in order to protect people from harm. One staff member commented, "Any suspicions are reported straight away." Another staff commented, "If I suspected abuse, I

Requires improvement

Is the service safe?

would talk with the person and complete an incident report." The safeguarding policy dated November 2014 detailed the procedures for staff to follow if they suspected abuse had occurred. The home's whistleblowing policy dated June 2014 outlined what should be done if anyone had concerns about practices in the home. Staff demonstrated an understanding of the policy and felt confident to inform management if they had concerns.

We reviewed a safeguarding alert that had been reported to the local authority. Correspondence between the service and the local authority evidenced appropriate action had been taken by the home.

People were protected as the service undertook safe recruitment procedures. Staff files contained written references, fully completed employment histories and medical questionnaires. Disclosure and Barring Service (DBS) checks had been undertaken. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with adults. Identification documents and health checks had also been completed.

People had the risks associated with their care assessed. These covered areas such as mobility, nutrition, moving and handling and generic risks. Care records clearly showed what action staff should take to ensure these risks were minimised. For example, one person was a smoker, a risk assessment was developed to ensure the person did not smoke in the building and how staff were to support the person to comply with this.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. A review of the service's medicines policy dated March 2015 showed it was comprehensive and ensured staff knew how to ensure people received their medicines safely. Medicines were stored safely, within their recommended temperature ranges and records were kept of medicines received and disposed of. We checked the content of the controlled drugs (CD) safe against the register and identified a discrepancy. This was raised with staff and rectified during our visit.

People's medicines were recorded within the medicines administration records (MAR), and the specific quantity administered were also recorded. A staff member explained how they applied creams to people as part of their personal care. The staff member showed us the records they kept. The frequency of creaming described by the staff member was reflected within the records. Each creaming plan was in two parts and "body maps", which were diagrams that outlined peoples' bodies, stated the product and described where the product was to be applied. However these records did not record the names of people they related to. We brought this to attention of management.

Care records contained personal emergency evacuation plans for people. This ensured in the event of an emergency staff would be able to evacuate people out of the building quickly. Information in the plans included their names, room numbers, general practitioner (GP) details and mobility needs. The service had a regulatory reform (fire safety) order 2005 fire risk assessment completed on 19 March 2015, this assessed any potential fire hazard to the building and any actions the home should take to ensure compliance with the fire safety legislation. We saw the actions taken by the home were appropriate.

We recommend that the service seek advice and guidance from a reputable source, about the management and monitoring of systems used in the home by people to summon help when required.

Good

Is the service effective?

Our findings

At our last inspection in June 2014 we found people waited significant periods for their meals and were not offered a visual menu of the choice of food on offer. Staff were task focused and had minimal contact with people during the lunch time period. Supplementary folders which contained monitoring records which recorded people's food preferences, were not accurate, factual or fit for purpose.

During this visit, people spoke positively about the food. We heard various comments such as, "It is brilliant and presented very nicely", "I like the food, I get what I want" and "I am happy with the food. I get a choice of fruit juices." A family member confirmed their relative ate well.

People were served their meals in a timely manner and were provided with choices of food and drink which met their needs. We noted people preferred to be told what was on the menu than read it. A staff member explained to a person the choices of meals on offer, the person chose what they wanted. Some people chose not to eat the food offered on the menu and were offered alternative meals instead. The atmosphere was relaxed and people ate their food at their own pace. Where people were being supported to eat their meals, we saw positive interaction between them and the staff who supported them. Staff were constantly engaged with the people they supported and did not leave the tables until people had finished their meals. People spoke with us about their food preferences and this was supported with what was written in their care records.

Care records clearly documented the links people had with the GP and other health care services. For example, we reviewed 'doctor resident review forms'. These captured dates the GP visited, notes of examinations undertaken and instructions given to staff. A healthcare professional spoke positively about how the home was effective in looking after one of their clients. They commented, "X is being well looked after, their identified needs are being met in a holistic manner. When staff have queries about X's mental health they will either contact me or the GP as a proactive measure."

People were supported by experienced and skilled staff. One person commented, "Staff are very efficient." Staff spoke positively about their induction and training. The project manager showed us the system used to ensure staff received appropriate induction and training. This recorded all training staff had completed on-line. The project manager stated staff were also expected to carry out practical assessments in areas such as, safer people handling and medical assessments. They emphasised staff would not pass their probation until their training program was completed. One staff member commented, "My induction was thorough and prepared me for what to expect. I enjoyed the on-line training and anything I wanted to know, I just had to ask." Another staff member told us, "I had a mentor who showed me the procedures I needed to follow. It was a very good induction. I identified my training needs and have received the training I have asked for." Another staff member said, "I think there is sufficient training however, staff need to access it." Training records showed staff were up to date with relevant training.

Staff told us they felt supported and felt confident to speak to the manager or their team leader if they required support. We heard comments such as, "I have received so much support from the manager", "We have not had regular formal meetings but I do know the new manager is looking to introduce this and make it more structured. I know I can speak to the manager for support and if they are not available, I would speak with their manager." Staff told us the benefits of appraisals. For instance, one staff member commented, "In my appraisal, I was able to express how I have improved in my job role and the manager was able to explain my strength and weaknesses." The manager acknowledged that one to one supervisions had not been carried out regularly by the previous registered manager and sent us a plan of how they were going to address this.

The service acted in accordance with the Mental Capacity Act 2005 (MCA). The MCA ensures the human rights of people who may lack capacity to take particular decisions are protected. Staff demonstrated good understanding of the MCA and training records confirmed they had undertaken relevant training. In the main reception, there was a large sign which displayed it was, 'Mental Capacity Awareness Month'. The poster showed the five principles of the MCA; the test used to assess someone's capacity; how staff should act in someone's best interest and day to day considerations. Where mental capacity assessments had been undertaken, these clearly recorded the outcomes. For instance, one care record showed a person received their medication covertly. A mental capacity assessment and

Good

Is the service effective?

best interest meeting had been undertaken. The service had sought specialist pharmacist advice on how to administer the medicines covertly and retain the medicines effectiveness.

People told us consent had been sought and obtained before staff carried out care, treatment and support. One person commented, “They always ask my permission first.”

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interest or it is necessary to keep them from harm. Providers of care homes are required to submit applications to a ‘Supervisory Body’ for authorisation when they believe a person’s liberty is being restricted. A review of DoLS applications that had been authorised showed the home had complied with the principle of the MCA. Staff demonstrated good understanding of what was lawful and unlawful restraint. One staff commented, “We don’t restrain people here, before using equipment that could restrict peoples’ movements such as bedrails, we ensure the necessary mental capacity assessment is carried out.” This ensured people were not being unlawfully deprived of their liberty.

Requires improvement

Is the service caring?

Our findings

At our last inspection in June 2014 we found people choices were not respected and people's social needs were not being met.

During this visit we saw people's choices were respected. People chose the meals they wanted, staff listened attentively and acted on their requests. Staff attended to the needs of people in a respectful way, we observed no negative interactions between staff and the people they provided care and support to. One person commented, "They listen to me and treat me with respect."

There was a lack of social activities for people who lived on the first floor dementia unit. One person on the first floor looked bored and unstimulated, once we started to talk with the person they became more interested and engaged. One staff member commented, "I would love to sit and talk to people, but I do not have enough time to do this."

The activity co-ordinator tried hard to accommodate people's needs but had to cover the two floors as well as take over from a care worker who was providing one to one care to an individual. There was no stimulation for people who did not come out of their rooms. For example, one person whose care record noted they preferred to stay in their room, received no stimulation. There was no sensory materials such as pictures or music made available to them. We saw no calendar clocks in the lounge to orientate people of the day and time and on the first morning of our visit, the radio was being played loudly in the corridor. This could have been a distraction for people living with dementia. This was addressed once we brought it to staff's attention.

On the ground floor we heard age appropriate music played in ground floor lounge. The activity co-ordinator enthusiastically interacted with a few people who were seated in this area. They asked people what music they wanted to listen to. Another staff member sang along jovially with people, everyone appeared to be having fun. We noted two people who on our last visit were restricted to their rooms, were now actively encouraged to spend time outside of their rooms. For example, staff had acknowledged the achievements of one person, and arranged for them to be the special guest at an community event they used to be involved with. Another person who spent most of their time in their room was now observed sitting in the communal area, engaging with other people and staff.

Not everyone felt the social activities in the home met their needs. A relative commented, "They (people) need more activities, they are always shown the same DVDs and listen to the same music." A person told us, "If you look outside you will see the bus parked in the drive way has been sitting there for four years. They can't find anyone to take us out anywhere in it."

Management told us they had been working to address this issue and had identified an organisation who would provide volunteers to befriend and meet people's social needs. We received confirmation of this after our visit which showed no definitive start date.

People told us staff were caring. We heard comments such as, "They are not bad, if I ask them for anything, they do it", "They look after me" ,"I am looked after well." Most of the relatives we spoke with told us staff were caring.

Staff were able to demonstrate their knowledge of the people they supported. This included detailed accounts of social and family history, food and drink preferences, daily routines and health and welfare. A review of care records supported what staff had told us.

We visited one person who was receiving end of life care. Throughout the day we saw different staff go in and out of their room to tend to their needs. We noted all observation records were completed and up to date. We saw staff monitored the person sensitively and effectively. One staff member commented, " I would like to ensure I am there in the person's last moments. I would not want to see someone die alone."

We recommend that the service finds out more about training for staff, based upon current best practice, in relation to social activities for people living with dementia.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. For example, one person on the first floor asked for two fried eggs for their lunch instead of the usual lunch menu. We observed a staff member responded to their request and promptly brought them the meal they had requested. The chef told us the local Speech and Language Therapy team (SALT) would make occasional visits to carry out assessments. SALT provided support to adults who had communication, cognitive or swallowing difficulties due to stroke, brain injury or neurological diseases. The chef stated the SALT team would give them instructions on how to meet people's nutritional needs and commented, "We are flexible and would change the menu to ensure people's needs are met." One care record documented a person who had been experiencing chest pains, was being regularly monitored. It noted the appropriate staff had decided the person needed to be taken to hospital, which was subsequently arranged. However we noted some changes in people's circumstances were not always referred promptly to health professionals, when required. We spoke with one relative who told us their family member had not been able to walk since they came out of hospital in November 2014. They stated the family member was now able to stand and grab onto railings but wondered whether a physiotherapist might be able to assist them to regain some of his mobility. We spoke with the nurse in charge who reported that the home did not have access to direct physiotherapy but they might be able to refer him to a physiotherapy via the GP. We fed back this information to management, who stated they would get this arranged.

People and those who represented them told us they were involved in the planning of their care. This was evident in the '7 day care plans' reviewed. These were developed with people and their relatives before they moved into the home and captured their preferences and needs. The manager told us these were reviewed again once people had settled into the home and appropriate changes were made to reflect people's current needs. There was clear evidence of all interested parties being involved in this process and subsequent decisions.

Care records contained people's likes, dislikes, cultural, religious and spiritual support required. The manager told us one person spoke fluent French so they arranged for a staff member who spoke French to be their key worker.

Risk assessments and care plans were relevant to identified needs and were up to date. Care records showed reviews of care were regularly undertaken. These evidenced families' and professionals' involvement and discussions held in regards people's changing needs.

The home had a complaints policy. This was clearly visible and displayed in the reception area for people and those who represented them to see. People told us they knew how to complain. We heard comments such as, "If I am not happy, I will tell them" and "I know who I can talk to if I am not happy." The project manager told us all complaints received were logged onto a on-line system to enable a thorough investigation and timely response. The manager told us they had not received any complaints.

The home had a hospital transfer information sheet which was completed on the day a person was being admitted into hospital. We reviewed a completed transfer information sheet for one person and saw there was sufficient information on the sheet to ensure the person would receive consistent, co-ordinated, person centred care.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in June 2014 we found systems to assess, monitor the quality of service provision was not being used effectively. During this visit we found that significant improvements had been made however, the staffing tool used to assess whether there was sufficient staff to support the needs of people on the first floor was not reviewed regularly. Management had acknowledged people's social needs were not consistently being met and were in the process of addressing this. However, it had been 10 months since this area of concern had been highlighted to them. We found there were no formal structured monitoring systems in place to see how staff responded to call bells and no evidence of action taken against staff who failed to respond in a prompt manner.

The home had three managers within the previous 10 months. People, those who represented them and staff gave mixed responses about how the home was managed. One person commented "They don't tell you what's going on, I prefer to keep to myself." A relative commented, "The managers are coming and going but I still think X is still looked after well." Some people told us they were not sure who the new manager was. Staff members acknowledged the manager was new but felt they were approachable.

Staff were confident about how to report any concerns about how the home was being managed and were aware of what procedures to follow. A review of minutes of staff meeting held on 13 November 2014, showed the previous registered manager expressed appreciation to staff for their hard work.

Staff told us the culture of the home was welcoming and relaxed. We observed the manager made themselves accessible to people, staff and visitors to the home throughout our visit. Their office door was only closed if they were not available. The manager told us their primary aim and objective was to ensure people and staff were safe, and the home delivered high quality evidenced based care. The manager was still settling into their position at the home and told us they had prioritised the work that needed to be done.

Quality assurance systems were in place and regularly monitored the provision of service such as, infection control audits, care plan audits and health and safety. For instance, care plan audits clearly noted areas of concerns, what actions were required and the dates staff had to action them by. We noted staff had acted within the specified timescales. Landlord's gas safety certificate recorded the home's gas appliances were safe. The home had an on-line system to capture all incidents, accidents and complaints. This enabled senior management to be aware of what was happening in the home and ensure appropriate actions were taken.

The service sought feedback from people and those who represented them. During our visits we saw a poster clearly displayed in the entrance of the home inviting relatives and people to a meeting. The meeting was scheduled for the evening of day two of our visit. We saw the items for the agenda included changes in management. We reviewed the minutes of a 'relatives and residents' meeting' dated the 7 November 2014. This showed people provided feedback on various areas such as cleaning, activities and food. However, the minutes did not clearly state the response from staff to the feedback received.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient levels of staff to meet the dependency needs of people on the first floor. Regulations 18 (1)